managers, and people change, innovation based on sustained investment disappears, and economic improvement is sluggish. National economic goals during this stage differ from before. Emphasis is placed on pursuing social welfare, but may people overlook the fact that social welfare is based on continual economic progress. I feel that these alarming observations are very meaningful.

Raising national competitiveness is for us the core of our reform, and is in line with professor Porter's ideas. However, we have not just established a national diamond of ''dynamic development,'' we have in fact instituted a project of national reinvention from a much broader angle. This task of raising national competitiveness is unique in concept and action, and deserves further elaboration for those people concerned about national competitiveness. First of all, it is global. Today, we are a member of the global village and neither can nor will exclude ourselves from international competition. Therefore, we must fully join in the globalization trend. There are many yard sticks and authoritative agencies for assessing international competitiveness, such as the International Institute for Management Development in Switzerland, and the World Economic Forum. They differ in the categories they evaluate and rank, and many factors tend to be subjective, but this is no excuse for our not pursuing competitiveness. If we want to compete in this world, we need to keep an eye on these evaluation factors, make judgments according to our own need, and decide on which evaluation categories we shall strive for. This way we can avoid being subjective and meet out real needs.

Second, it is comprehensive. When we talk of competitive advantage, many people immediately associate it with such economic meanings as an increase in national financial might or a boots in productive power.

Undoubtedly, these factors constitute a major portion of what national competitive advantage means. However, we believe that competitive advantage means more than just economic issues; education, public safety, the quality of life, and technical might are all part of the concept. In particular, at this present stage.

## PROVIDING FOR CONSIDERATION OF CONFERENCE REPORT ON H.R. 3610, DEPARMENT OF DEFENSE APPROPRIATIONS ACT, 1997, AND PASSAGE OF H.R. 4278, OMNIBUS CONSOLIDATED APPROPRIATIONS ACT, 1997

SPEECH OF

### HON. CARDISS COLLINS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

*Saturday, September 28, 1996*

Mrs. COLLINS of Illinois. Mr. Speaker, on Saturday, September 28, 1996, the House of Representatives was presented with the conference report to H.R. 3610 containing the omnibus appropriations for Federal fiscal year 1997. At the time that the bill was called up on the House floor for a vote, no Member had yet read and analyzed the entire bill, with groups of staff members working on various parts of that legislation. When we were presented with the legislation, I stated that because I had not been offered the opportunity to be advised of numerous provisions about which I have particular concern, I would vote against the measure.

Between the time my statement was given for the RECORD, and the time at which I cast my vote, some of my concerns had been resolved. Therefore I cast my vote in favor of H.R. 3610.

## VETERANS' HEALTH CARE ELIGIBILITY REFORM ACT OF 1996

### HON. TIM Y. HUTCHINSON

OF ARKANSAS

IN THE HOUSE OF REPRESENTATIVES

*Monday, September 30, 1996*

Mr. HUTCHINSON. Mr. Speaker, it is with great pride and a resounding sense of accomplishment that I stand in support of H.R. 3118, as amended, the Veterans Health Care Eligibility Reform Act of 1996. This bill represents the culmination of strong bipartisan efforts to move Veterans' Administration [VA] health care into the 21st century. I want to extend my appreciation to Chairman STUMP for his leadership and to the ranking members SONNY MONTGOMERY and CHET EDWARDS of the Veterans Affairs' Committee for their steadfast support in doing what is right for America's veterans.

H.R. 3118, within appropriations, directs VA to provide all needed hospital and medical care services and establish and manage health care programs to promote the cost-effective delivery of health services to veterans with compensable service-connected disabilities, former prisoners of war, veterans exposed to toxic substances and environmental hazards, veterans meeting the ''means test'' as provide under existing law, and veterans of World War I.

The bill requires VA to manage the provision of health care services through an annual patient enrollment system that is reflective of the priority system, which provides the highest priority for enrollment to those with service-connected conditions and also requires that effective October 1, 1998, veterans enroll in a VA managed care plan to receive health care services. Veterans in need of care for a service-connected condition of 50 percent or more service-connected disabled are exempt from the enrollment requirement.

The bill eliminates restrictions on VA providing prosthetics, but requires VA to establish guidelines for providing hearing aids and eyeglasses.

The bill directs the VA to maintain its capacity for specialized services at the current level and within distinct programs and facilities dedicated to the specialized needs of those veterans. It also requires VA to consult with the Advisory Committee on Prosthetics and Special Disabilities Programs and the Committee on Care of Severely Chronically Mentally Ill Veterans in the assessment of these activities. Furthermore, the VA is required to report to the House and Senate Veterans' Affairs Committees by April 1 of the years 1997, 1998, and 1999 on VA's compliance with the specialized services provisions of the bill.

To ensure the budget neutrality of the eligibility reform provisions of this bill, the authorizations for appropriations are capped at the following amounts: $17.25 billion for fiscal year 1997 and $17.9 billion for fiscal year 1998.

The bill requires that no later than March 1, 1998, VA report to the House and Senate Veterans' Affairs Committees on the impact of the implementation of eligibility reform.

The bill authorizes the following major projects for a total amount of $358.15 million: construction of an ambulatory care facility and renovation of ''E'' wing, Tripler Army Hospital, Honolulu HI, $43 million; addition of ambulatory care facilities, Brockton, MA, $13.5 million; addition of ambulatory care facilities, Shreveport, LA, $25 million; addition of ambulatory care facilities, Lyons, NJ, $21.1 million; addition of ambulatory care facilities, Tomah, WI, $12.7 million; addition of ambulatory care facilities, Asheville, NC, $26.3 million; addition of ambulatory care facilities, Temple, TX, $9.8 million; addition of ambulatory care facilities, Tucson, AZ, $35.5 million; construction of an ambulatory care facility, Leavenworth KS, $27.75 million; environmental improvements, Lebanon, PA, $9.5 million; environmental improvements, Marion, IL, $11.5 million; environmental improvements, Omaha, NE, $7.7 million; environmental improvements, Pittsburgh, PA, $17.4 million; environmental improvements, Waco, TX, $26 million; environmental improvements, Marion, IN, $17.3 million; environmental improvements, Perry Point, MD, $15.1 million; environmental enhancement, Salisbury, NC, $18.2 million; and seismic corrections of building number 324 at the Department of Veterans Affairs medical center, Palo Alto, CA, in the amount of $20.8 million. The authorization covers the fiscal years 1997 and 1998.

The bill authorizes the following major medical facility leases for a total of $12.236 million: Allentown, PA, $2.159 million; Beaumont, TX, $1.94 million; Boston, MA, $2.358 million; Cleveland, OH, $1.3 million; San Antonio, TX, $2.256 million; and Toledo, OH, $2.223 million.

The bill requires the VA to develop a 5-year strategic plan for its health care system which specifically addresses the integration of planning efforts at the grassroots level, coordinated within the prescribed geographic network, and then formulated into a national plan. The plan is required to be updated annually.

The VA is also required to submit to the House and Senate Veterans' Affairs Committees an annual report on the top 20 major medical construction projects of the Department which includes the justification of the projects and any changes to the report, such as the addition, deletion, or change in rank order of any of the projects.

The bill expands the required documentation and justification of each major project and major facility lease proposed in the President's budget. The bill redefines a major medical construction project as costing at least $4 million and repeals effective fiscal year 1998, a provision of law exempting certain previously funded construction projects from the law's authorizations requirement. The bill also provides that amounts in excess of $500,000 may not be obligated from the VA's Advance Planning Fund until VA reports such proposed obligations to the House and Senate Veterans' Affairs Committees.

The provision of Health Care Sharing and Administration broadens and expands VA's ability to share health care resources while ensuring that services to veterans are not adversely affected by contractual agreements or sharing arrangements that may be established between the VA and other health care providers.

The bill makes permanent VA's ability to enter into sharing agreements with the Department of Defense under provisions of DOD's CHAMPUS program. The bill clarifies VA's authority to recover or collect from insurance